HIPAA PRIVACY IMPLEMENTATION SCHEDULE

Department:	Program/Function:	Date/Version:

Program/Function HIPAA Status: _____Health Care Provider, _____ Health Care Plan, _____ Health Care Clearinghouse, _____ Trading Partner, _____ Business Associate, _____ Data Changes Impact, _____ Affiliated Entity, _____ Multi-functional Entity

		Task or Activity	Activity Number from State Law Baseline	Description	Resources	Steps to HIPAA Compliance*	Start Date	Percent Completed	Projected End Date	Actual End Date
1		**Mapping PHI [45 CFR 164.502, 164.504(e)]**	**2 & 3**	Protected Health Information (PHI) is individually identifiable health information that is created or received by a coverd entity (or a business associate acting on behalf of a covered entity).	~Draft Napa County mapping tool. ~Research Work Group mapping questionnaire. ~Research Work Group PHI data flow map (being developed).					
	1A	PHI in the Covered Entity [45 CFR 164.502]	2	Map or flow chart the location of PHI within your department, program, or function.						
	1B	PHI outside of the Covered Entity [45 CFR 164.504(e)]	3	Map or flow chart the PHI you exchange with outside organizations with which you have a business relationship.						
2		**Gap Analysis**	**5, 6, 11, 23**	Compare current business practices with the HIPAA requirements to identify what different business practices should be occuring to be HIPAA compliant.						
	2A	Current Business Practices [45 CFR 164.502]		Identify and document your current business practices that include the location of all PHI, the purpose, use/disclosure, and the identification of the workforce member with access to PHI.	~PHI map/flow chart prepared in Tasks 1A & 1B					
	2B	HIPAA Requirements - Use/Disclosure of PHI [45 CFR 164.502 - .514]	5, 6	1. Identify and document the HIPAA requirements for each business activity performed by your program to use in identifying the gap between current practices and HIPAA requirements. 2. Identify and document permitted uses and disclosures of PHI for your business practices. 3. Identify PHI into categories: For treatment, payment, health care operations or other activities. 4. Determine if the PHI requires an authorization for release. 5. Determine your policy on the minimum necessary for PHI use and disclosure. 6. Determine the level of confidentiality of the information, e.g., public; public but not advertised; not public, but available to the client; or never to be released (public health hazard, health and safety of individual).	~CalOHI Information Memorandum 2002-04, HIPAA Privacy State Law Baseline ~Federa HIPAA regulations are availiable in CalOHI web site: www.ohi.ca.gov					

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	2C	Identification of Differences - "**GAP"** [45 CFR 164.502]		Identify and document the **gap**, the differences between your current practices and the HIPAA requirements, if any.	~Solano County sample flow chart. ~Gap analysis template and instruction under development.					
	2D	New Business Practices		Identify the new business practices that are necessary to be HIPAA compliant and changes to those existing practices that are necessary.						
	2E	Process to Achieve Change		Identify existing administrative processes needed to make the business practice changes, e.g., regulation changes, executive approval, Board of Supervisor approval, desk procedure changes, union buy-in, etc.						
	2F	Documentation Requirement [45 CFR 164.530(j)]	5	Identify the activities in your business practices that HIPAA requires to be documented and incorporate the documentation requirements into the new business practices.						
	2G	Safeguards [45 CFR 164.530(c)]	23	Have in place administrative, technical and physical safeguards to protect the privacy of PHI.						
	2H	Commercial Uses of PHI [45 CFR 164.501. 164.508(a)(3), 164.514(f)	11	Identify any current use or disclosure of PHI for marketing, fundraising and develop policies that will limit use.	~Discussion of marketing is in the preamble of the final August 14, 2002 federal HIPAA privacy regulations - federal regulations available on CalOHI web site (www.ohi.ca.gov). ~Federal Guidelines - 7-16-02 @ http://www.hipaadvisory.com/regs/finalprivacy/guidance.htm					
3		**REMEDIATION** [45 CFR 164.534]		Implement the business practice changes needed to become compliant with HIPAA Privacy requirements no later than **April 14, 2003**.	Use your Gap Analysis and new business pactices (2C and 2D) to identify when a process has been remediated.					

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4		**PREEMPTION**		Use the current business practices and the applicable HIPAA regulations in the Gap Analysis to identify the State laws that are applicable to that practice. The preemption analysis should be completed by legal counsel or under the supervision of legal counsel.	~Gap analysis template & instructions (under development). ~CalOHI Policy Memorandums: 2002-02 - Identification and HIPAA Preemption Analysis of State Law Relating to the Confidentiality and/or Privacy of Individually Identifiable Health Information 2002-06 - Preemption Analyses of the Information Practices Act and the California Public Records Act CalOHI Information Memos: 2002-03 - Courtesy Copies of COHI Requests for Identification and HIPAA Preemption Analysis of State Law Relating to the Confidentiality and/or Privacy of Individually Identifiable Health Information 2002-04 - HIPAA Privacy State Law Baseline					
	4A	Applicable State Laws [45 CFR 160.202, 160.204]	12, 13, 14	Document the applicable State laws (and regulations) that apply to the use of PHI for the business practices.	~ HIPAA Legal Counsel ~ http://www.leginfo.ca.gov/calaw.html ~ http://www.privacyprotection.ca.gov/ ~ http://www.healthprivacy.org/ ~ CalOHI website: www.ohi.ca.gov in section HIPAA Rules/Legal Issues; Subjects: Privacy; Transactions and Code Sets					
	4B	State Laws Preempted by HIPAA [45 CFR 160.202, 160.204]	12, 13, 14	Identify and determine resolution (either change in state law or exception from DHHS) for State laws that are preempted by HIPAA. Your legal counsel should complete the Preemption Analysis chart or use the templates located on CalOHI's website to complete the preemption analysis of your program's specific privacy State laws and regulations.	~ Department's HIPAA Legal Counsel ~ http://www.leginfo.ca.gov/calaw.html ~ http://www.privacyprotection.ca.gov/ ~ http://www.healthprivacy.org/ ~ CalOHI website: www.ohi.ca.gov in section HIPAA Rules/Legal Issues; Subjects: Privacy; Transactions and Code Sets					
5		**Business Associate** [45 CFR 164.504(e)]	**3 & 31**	Identify which organizations are business associates of the covered entity.	~ Federal Guideline 7-6-02 @ http://www.hipaadvisory.com/regs/finalprivacy/guidance.htm ~ Sample Business Associate Contract in August 14, 2002 federal HIPAA privacy regulations @ www.ohi.ca.gov - Privacy.					
	5A	Define and Identify [45 CFR 160.103]		Define in relation to your business practices: - what/who is a business associate, and - your role as a covered entity with each business associate	PHI map/flow chart prepared in tasks 1A & 1B.					

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	5B	Agreement (Contract) [45 CFR 164.504(e)(1) & 164.532(e)]	31	Develop business associate contract/contract language that requires business associates to comply with HIPAA.	A sample business associate agreement exists in the August 14, 2002 federal HIPAA privacy regulations.					
6		**Staffing**	**1, 8, 9, 10, 20, 21, 35, 36**	1. Designate staff to implement HIPAA requirements 2. Identify staff members or classifications of staff who have access to PHI						
	6A	Privacy Officer [45 CFR 164.530(a)]	1	1. Appoint an individual who will be the HIPAA Privacy Official and document in your Privacy Policies and Procedures. 2. Develop the duty statement of the HIPAA Privacy Officer.	A draft privacy officer template has been completed by the Privacy Sub-Work Group.					
	6B	Staff with PHI [45 CFR 164.514(d) & 164.530(a)]	8, 9, 10	Using your Gap Analysis that identified the staff members (employees or volunteers) with access to PHI, identify: ~the minimum PHI that is need for the activity/function performed, ~the appropriate level of access to PHI by each staff member. Note: Organizations may identify by individual staff members (position numbers) or by classifications.	~Gap analysis (2C) ~Federal Guidelines - 7-16-02 @ http://www.hipaadvisory.com/regs/finalprivacy/guidance.htm					
	6C	Training [45 CFR 164.530(b)]	20	1. Develop training plan. 2. Prepare privacy training tool. 3. Train and document the receipt of training for all members of your staff/workforce on privacy policies/procedures.						
	6D	Complaints ~Point of Contact for Access [45 CFR 164.530(d)] Retaliatory Acts [45 CFR 164.530(g)]	35, 36	1. Identify an individual to accept complaints and institute a process for individuals to file complaints concerning breaches of privacy or protests of policies and document in your Privacy Policies and Procedures. 2. Develop a policy to prevent intimidating or retaliatory acts against individuals filing complaints.						
	6E	Access/Disclosure Point of Contact 45 CFR 164.524(e) & 164.526(f)		Identify individual(s) within your agency who organizations/ individuals can contact to access PHI and document in your Privacy Policies and Procedures.						
	6F	Sanctions [45 CFR 164.530(e)]	21	Review personnel procedures to ensure they include the consequences for violation of HIPAA requirements in employee's work agreements.	A draft sanctions template has been completed by the Privacy Sub-Work Group					

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7		**Notice of Privacy Practices** [45 CFR 164.520]	**18**	Develop a notice of privacy practices that explains the use/disclosure of PHI policies, and distribute to customers. Decide on option to have clients sign the notice.	Draft Notice of Privacy Practices developed by LA County					
8		**Documentation of Policies and Procedures** [45 CFR 164.530(i) & (j)]	**17**	Develop, implement, and maintain your HIPAA Privacy Policies and Procedures.						
	8A	Retention of Records [45 CFR 164.530(j)]	38	Implement a retention period of 6 years for HIPAA required documentation.						
9		**Access** [45 CFR 164.524]	**15, 25, 27, 28, 30,**	Develop a process that will allow individuals access to inspect and/or copy their PHI, including denial of access when appropriate.						
	9A	Process to Access [45 CFR 164.524] ~Confidential Access [45 CFR 164.502(h) & 164.522(b)(1)	27	Develop procedures that allow individuals access to their records, e.g., email, internet, in person, in writing, etc., including a process for confidential access.						
	9B	Designated Records Set [45CFR 164.501& 164.524(a)]	25	Define the designated records set that will be accessible by individuals.						
	9C	Identification of the Individual [45 CFR 164.514(h)(1)]	28	1. Develop a process to verify the identity of individuals requesting access to records. 2. Develop a process to verify the identity and right of access of authorized representatives requesting access to an individual's record.						
	9D	Amendments to PHI [45 CFR 164.526]	30	Develop a process that will allow individuals to provide amendments to their PHI. This includes a process for refusal of the amendments and documentation requirements.						
	9E	Timely Access and Fees for Copies of PHI Records [45 CFR 164.524(b)(2) & (c)(4)]	15	Develop a process to provide copies of records to individuals within the defined time limit, and a policy on the amount to be charged for copies of PHI.						

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10		**Disclosure** [45 CFR 164.502-.514]	**17, 22, 32, 33, 34**	Develop a process that will allow for disclosure of PHI to other individuals or organizations. The process should detail what is allowed to be disclosed, when it is allowed to be disclosed and a process to determine the minimum necessary to meet the purpose of the requestor. It should include identification of the staff who can make the judgments as to the minimum necessary.						
	10A	Authorization [45 CFR 164.508]	32	Develop an authorization form that is signed by the individual to allow disclosure of PHI and a process to revoke the authorization.						
	10B	Minimum Necessary [45 CFR 164.514(d)]		Define a process to limit PHI disclosed to the minimum necessary for the purpose.	Federal Guidelines - 7-16-02 @ http://www.hipaadvisory.com/regs/finalprivacy/guidance.htm					
	10C	Documentation [45 CFR 164.508(b)(6) & 164.530(j)	17	Develop a process to document: ~ what PHI is released, ~ to whom the PHI is released, and ~ how the authorizations will be retained.						
	10D	Accounting of Disclosures [45 CFR 164.528]	34	Develop a process that allows an individual to request and receive an accounting of the disclosures of their PHI for the prior 6 years, if requested.						
	10E	Restricted Release [45 CFR 164.522(a)]	33	Develop a process that allows individuals to restrict use and disclosure of PHI.						
	10F	Transition [45 CFR 164.532]	22	Develop a process to transition existing consents or authorizations that have agreed-to restrictions to HIPAA compliant consents or authorizations.						
11		**Research with PHI [45 CFR 164.512(i)]**		Develop a process that will allow for permitted uses and disclosures of PHI for research.						
	11A	De-Identification of PHI [45 CFR 164.514]	37	Determine if use of limited data sets or de-identification of data will be used. ~ If so, develop a process to de-identify PHI data or alter PHI into limited data sets to allow for disclosure to other organizations, e.g., data needed for reporting to other agencies or for research. ~ The process should include who is permitted to de-identify data and approve release of de-identified data, how it is completed and which data is allowed to be de-identified, and which data is exempt from de-identification (such as data released to FDA).	Federal Guidelines - 7-16-02 @ http://www.hipaadvisory.com/regs/finalprivacy/guidance.htm					

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*** Steps to HIPAA Compliance: 1) Project Initiation (Awareness) 2) Initial Assessment (Inventory) 3) Prepare Project Plan 4) Detailed Assessment (Gap Analysis) 5) Implementation and Testing**

This material should be used in the context of your own organization and environment. CalOHI encourages departments to obtain legal opinions or decision documentation if needed to apply or interpret HIPAA regulations.